

APPENDIX C, EXHIBIT 3

COMMUNITY AND SENIOR SERVICES (CSS) SPECIALIZED TRANSPORTATION RESOURCES AND INFORMATION FOR THE DISABLED AND ELDERLY (STRIDE) BUDGET/PROPOSED PROGRAM SERVICES (PPS)

INSTRUCTIONS

Please use the following instructions to complete the attached electronic *Budget/Proposed Program Services (PPS)*. The worksheet has been protected to preclude changes to key fields/cells except for designated areas which shall be completed by the Proposer. The form automatically performs all necessary calculations and validations. Please note that the workbook contains two (2) Exhibits (*Budget* and *PPS* forms); the Proposer shall complete the applicable sections of each Exhibit in order to accurately reflect the Services to be provided for the fiscal year. When working with calculations, any additional information other than whole numbers will often create mathematical variances therefore, please refrain from using formulas or decimals (unless allowed by the sheet).

PART I - APPENDIX C - EXHIBIT 1

Cover Sheet: Please provide all requested information. Once the agency data has been entered, the Contractor's name will automatically generate on all pages of the workbook.

1. **Enter the Full Legal Name of the Organization:** Enter the full legal name of the organization onto the line and do not abbreviate. The name listed must match the name on the Articles of Incorporation, Business License, Charter, or By-Laws.
2. **California Public Utilities Commission Certificate (CPUC) Number:** Enter the certificate, permit, or registration number provided by the CPUC.
3. **Main Administrative Office Address:** Enter the address of the authorized signatory on this line. If the main administrative office and the mailing address are the same.
4. **City/State/Zip Code/Fax Number:** Please enter all the information listed corresponding to the particular site. Note: For the FAX number, enter only numbers with no spaces, hyphens, parenthesis or any additional characters (i.e., 2223334444).
5. **Mailing Address:** Only enter an address if the Main Administrative Address and mailing address are different. All correspondence, contract, program and compliance related information will be sent to both addresses and addressed to

the administrator listed on the Authorized Signatory and the Secondary Contact lines.

6. **Official Authorized to Sign for the Agency:** Enter the administrator authorized through board resolution to sign for the agency. A board resolution will be required prior to contract execution.
7. **Job Title:** Enter the title of the authorized signatory. Please abbreviate the job title if the title does not fit in the cell.
8. **Phone Number/Ext.:** Enter the phone number and extension of the contact. Note: For the phone number, enter only numbers with no spaces, hyphens, parenthesis or any additional characters (i.e., 2223334444).
9. **E-Address:** Enter the email address of the contact.
10. **Secondary Contact for Program:** CSS will only contact the secondary contact in cases where the authorized signatory is not available.

Budget Overview:

1. **Funding Categories:** Enter the amount of funding necessary to operate the Program. The funding categories (i.e., the sources of revenue) include: Contract Costs (funds allocated and reimbursed by CSS), Match (in the form of Cash or In-Kind contributions), and Program Income.
 - a. Program Income: Revenue generated by Proposer from contract-supported activities including, but not limited to, voluntary contributions; royalties received on patents/copyrights from contract-supported activities; and proceeds from the sale of items fabricated under a contract agreement.
- I. **Personnel Detail:** Please complete as follows:
 1. Position Titles: Enter the title of each staff member who will work on the Program. Abbreviate the job title if the title does not fit in the cell.
 2. Column (A) No. of Employees: Enter the number of employees for this position with similar pay and percentage of time.
 3. Column (B) % of Time on Program: Enter the percentage of time the employee(s) will spend working on the Program. Use a separate line to report this information if the percentage of time will vary for employees with the same title.

4. Column (C) Monthly Salary: Enter the total Monthly Salary for this position. Do not enter hourly rates. Estimate the Monthly Salary if the employee is paid by an hourly wage.
 5. Column (D) No. of Months: Enter the number of months the employee will be paid under the Program up to a maximum limit of 12 months.
 6. Column (E) Annual Salary: Do not complete this field; the total will be calculated automatically. Please note all preceding cells must have data entered before this total will work.
 7. Column (F) Contract Costs: Enter the amount of the Grant Award that will be used to fund the annual salary for this position.
 8. Column (G) Match (Cash/In-Kind): Enter the amount of Match in the form of either Cash or In-Kind contributions that will be used to fund the annual salary for this position.
 9. Column (H) Program Income: Enter the amount of Program Income that will be used to fund the annual salary for this position.
 10. Column (I) Budget: Do not complete this field. This amount should equal column (E) Annual Salary.
- II. **Taxes:** Highlighted in yellow (Lower left-hand corner); Enter the total percentage representing payroll taxes. Calculations for taxes must be completed manually. Note: Column (E) and column (I) must be equal.
- III. **Benefits:** Highlighted in yellow (Lower left-hand corner). Enter the total percentage representing employee benefits. Calculations for benefits must be completed manually. Note: Column (E) and column (I) must be equal.
- IV. **Other Costs:** In the space provided, enter the type of cost that will be utilized during the fiscal year. All costs must be program related. Complete the columns as follows:
1. Column (A) Unit Cost: Enter the cost per unit of the item(s). The Unit Cost must be as reflective of the actual cost as possible. Although costs may differ from month to month please provide the best estimated Unit Cost possible.
 2. Column (B) Number of Units: Enter the estimated or agreed reimbursement schedule/rate per month. For example, if you are paying for services biweekly then the costs should be reflected as: Agreed Unit Cost/Rate of Reimbursement * 2 (for the number of times your agency will reimburse this Sub-Contractor for one month) * 12 (months).

3. Column (C) Number of Months. This is limited to 12 months.
4. Column (D) Total Cost: Do not complete this field. You must enter a numeric value in column (A), (B), and (C) in order for column (D) to calculate automatically.
5. Column (E) Contract Costs: Enter the amount of the proposed Grant Award that will be used for the line item.
6. Column (F) Match: Enter the amount of the Proposer's Match in the form of Cash or In-Kind contributions.
7. Column (G) Program Income: Enter the amount of proposed Program Income.
8. Column (H) Budget: Do not complete this field. This amount should equal column (D) Total Cost.
9. Special Exceptions:
 - a. **Space:** Space must be calculated by **cost per square foot**. This amount must be a fair market value and supported by documentation.
 - b. **Equipment:** For single unit purchases over \$1,000 refer to the *Unique Terms and Conditions* and *Standard Terms and Conditions* for more information.
 - c. **Mileage:** Must be calculated by the cost per mile and the estimated number of miles. The cost per mile can't exceed the IRS Mileage Reimbursement rate.

PART II - APPENDIX C - EXHIBIT 2

V. Escort Driver Services

1. **Unit Rate:** Indicate the Unit Rate your agency proposes to charge per hour.
2. **Hours:** This will be calculated automatically (Total Contract Costs/Unit Rate).
 - a. **Billing:** Trips lasting less than an hour shall be billed in minute increments. For example, a trip lasting one hour and fifteen minutes shall be billed as 1.25.
3. **Total Cost:** The Total Cost will be automatically calculated based on the data entered.

4. **Number of One Way Trips:** Indicate the number of one-way trips your agency plans to provide during one fiscal year.
5. **Cost Per One-Way Trip:** This will be calculated automatically when all the other fields are filled.

VI. **Proposed Service Area(s)**

1. Place an "X" to the right of each Supervisorial District (SD) you plan to serve.
2. In the space indicated, provide the name of each city and unincorporated areas of the County you plan to serve. Please list the target areas in alphabetical order.

VII. **Vehicle Information:** Please provide the information as requested.

1. License Plate
2. State the vehicle is registered in
3. Vehicle Identification Number (VIN)
4. Manufacturer
5. Year
6. Model
7. Seats: Identify the number of seats per vehicle including the driver.
8. Equipment: Adaptive equipment such as wheel chair racks, swivel chairs, etc. that will enhance the Escorts Driver's ability to provide services.

VIII. **Dispatcher Sites**

1. Site Name: Provide the site name.
2. Service Area(s): State the areas covered by the dispatcher site.
3. Contact and Phone Number: Provide the full name of the Contact as well as his/her direct phone number.
4. Days/Hours of Operation: Enter the hours the Site is open for Services under the appropriate column according to the days of the week (Monday through Friday [M-F], Saturday [Sat] and/or Sunday [Sun]). For example, if the Proposer intends to provide services on Monday, Wednesday, Friday, Saturday and Sunday then data would be entered as follows: (1) under column (M-F) enter: Mon, Wed & Fri – 12 pm – 3 pm & 5 pm – 8 pm; (2) Under column (Sat) enter 12 pm – 3 pm & 5 pm – 8 pm; and, (3) under column (Sun) enter 12 pm – 3 pm & 5 pm – 8 pm. If your agency will provide services during holidays, please state "Yes" or "No".